Greater Hazleton Health Alliance Medical Staff Link

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Welcome

New GHHA Medical Staff Members

Jill T. Snyder, D.O.
Obstetrics/Gynecology

Gary R. Decker, M.D.
Infectious Disease

Mary Louise Decker, M.D.
Infectious Disease

Linda A. Slavoski, M.D.
Infectious Disease

Jose Castillo, M.D.
Locum Tenens - Medical Oncology

Kerry Rosen, M.D.
Pediatric Cardiology

Jesse Goldman, M.D.
Locum Tenens - Nephrology

Senen N. Alday, M.D.
Locum Tenens - Anesthesiology

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Thank You

A special thank you to all the physicians who made a contribution to the Gifts for Teen Tree. Because of your help we were able to buy gifts for approximately 90 teens whose ornaments were on the tree. Also, because of your generosity all 300 teens were given gifts.

PHYSICIAN'S PLEASE REMEMBER.....

VERBAL AND PHONE ORDERS

Verbal and Phone orders need to be signed and dated as soon as possible after the order is given. Don't forget to **date your signature** when you sign the order. This is a charting requirement of the state licensure board. These are suppose to be signed within 24 hours.

PHYSICIAN PROMOTIONAL ACTIVITY

In 2001, the Alliance will be initiating another promotional campaign for local physicians' practices.

If you have an interest in being included in this promotional effort, please indicate to us your interest by personal communication or by leaving word at either Medical Staff Office; Hazleton General Hospital 501-4142 or Hazleton Saint Joseph Medical Center 501-6198.

PROPER DIAGNOSIS

It is **important** that physicians give the proper diagnosis for stress tests, holter monitors and echocardiograms for inpatients as well as out patients.

The out patient should have a script with the proper test to be done and also the accurate diagnosis.

CHART DOCUMENTATION TIPS

Medical records are routinely reviewed for the presence of required documents, accuracy, timeliness, legibility, completeness, and authentication. The following is an outline of the required CONTENT items for the History and Physician Examination and the Consultation:

History and Physical Examination

- *Chief Complaint*
- *History of Present Illness*
- *Relevant Past History*
- *Relevant Family History*
- *Relevant Social History*
- *Inventory of Body System*
- *Summary of Patient;s Psychosocial needs*
- *Relevant Physician Examination*
- *A statement of Conclusions or Impression*
- *Plan of Care*

The history and physical examination must be recorded within 24 hours of admission by the admitting physician or his/her designee.

Consultation

- *Written Opinion of the Consultant*
- *Actual Examination of the Patient and the Medical Record*
- *Recommendations by the Consultant*

The attending practitioner must indicate in writing on the consultation record the reason for the consultation request and the extent of involvement in the care of the patient expected from the consultant, e.g. for consultation and opinion only.

Please note that the History and Physical is not the same thing as the Consultation. A physician other than the patient's attending physician completes the Consultation.

OBSERVATION STATUS

Observation is a period in which the patient requires some level of active monitoring or evaluation by medical personnel. The physician must make a decision, based on the clinical information available, whether the patient needs to be admitted as an inpatient or treated and sent home. Observation is appropriate if additional testing and monitoring is required in order to make such a decision. If, after monitoring or further testing, the patient's status need to be changed to inpatient, it can be done with a simple order, and inpatient services will be reimbursed. If, however, a physician writes an inpatient admission rather than an observation order, when only monitoring or testing is needed, and chart is reviewed by KePRO or other entities shows that inpatient care was neither needed nor legitimately anticipated, the hospital faces a payment denial.

The need for observation is not something that can be determined before it occurs. For a patient to be placed in observation following an outpatient surgical episode, the patient must demonstrate a need for continued monitoring beyond the standard post-op monitoring period. This need, which may be due to a complication, unusually slow recovery, or some other unexpected event, cannot be predicted until it occurs, and certainly not before surgery even begins. If the need for unusually intense post-op care is anticipated, maybe the patient should undergo surgery as an inpatient.

Observation is basically a "wait and see" period, a period in which evaluation and monitoring will occur and when a disposition will be decided. Observation can't be billed when the physician knows from the start that he/she plans to admit the patient as an inpatient, nor should it be ordered to follow surgery Boer the surgery has even occurred.

According to the Ambulatory Payment classifications (APC), observation services will be packaged whenever they are billed. For example, if a patient comes to the emergency room and is then placed in observation, the APC payment for the emergency room visit will include the cost of observation within that payment. The patient must have an encounter with a health care professional in the emergency room or another clinic setting in the hospital in order for observation services to be reimbursed. Additionally, direct placements into an observation setting from the physician's office will not be reimbursed.

A Special Thank You.....

Since this will be the last newsletter before the new year, I would like to take this opportunity to thank the entire Medical Staff for all your assistance throughout the past year.

A Happy and Healthy New Year!
Judy A. Ervin
Medical Staff Assistant, Editor